MDS 3.0 Section Q Implementation Questions and Answers
June 2011 Addendum

ASKING THE SECTION Q QUESTIONS[1]

1. What can be considered an "active discharge plan" and how should it be coded?

Background:
Training guidelines and information indicate that at the end of review there will be a clear understanding of what can be considered an "active discharge plan" as well as coding for same. Some facilities have been challenged on how to correctly code this question. It is and will continue to be important for all of us to have a clear understanding of what is an active discharge plan; especially when many facilities may have a discharge plan for a resident that indicates that the resident will be discharged at the completion of services and treatments. No specific time frame is able to be given for some discharges from many months to more than a year and there may be waiting lists for housing. Discharges with long time timeframes may have a discharge plan that includes referral to home care agencies. 85% or more of admissions appear to come from the hospitals. Those that are on Medicare for rehab typically go home once their rehab ends. This is not the population group that would benefit from these questions. CMS should develop some sort of screen for this question because currently it confuses residents and families who are on the facility's rehab and discharge track.

A discharge plan includes the steps/course of action that must be in place in order to discharge the resident. An active discharge plan is part of the resident's care plan for discharge, with specific measurable objectives/goals developed with the expertise of the interdisciplinary team; each team member as appropriate working to accomplish resident's goal for discharge. The admission assessment and development of the resident's initial care plan should prepare for the resident's discharge or potential for discharge. It should list the resident's needs and preferences after discharge; describe the current status of planning and processes that are actively in motion to determine and arrange services and supports for the resident to go home or to another community setting; who is assisting the resident and arranging supports and services; who else (what other agencies or entities) are involved; target dates for decisions and arrangements, and a target discharge date. After review of Section Q and other relevant MDS 3.0 questions the team should reevaluate responses and interpretation of the same and make changes as deemed appropriate, assess whether there are adequate or available settings and resources to accommodate the resident's needs and wishes, and whether or not there are available resources to support the resident. The return to community and other care area assessments (CAAs) can provide a means of gathering information that is useful in assisting the interdisciplinary team in determining the resident's status and resources necessary for the resident to meet his/her goal for discharge to home or another setting. The social worker's role is critical in facilitating communication with the resident, family, significant others, other interdisciplinary team members and access to community resources in assisting the resident in meeting his/her discharge goals.

[1] Additional Section Q coding Q & A responses can be found on pages 1-4 under download 'MDS3_0_Section_Q_Implementation_problems and solutions' at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp

The intent of the active discharge plan item is to determine that there is a discharge plan in place, which does not require that the resident be asked the return to community Q0500B question. CMS realizes that particularly for newly admitted Medicare SNF residents, there may be a targeted discharge date and discharge plan for follow-up medical, home health, and/or durable medical equipment services already in place, (i.e. the resident has a home to return to which may include a family member as caregiver, a local home care agency and medical equipment provider, etc.). Additionally, some non-Medicare and Medicaid residents may have resources, informal and formal supports, and finances already in place that would not require referral to a local contact agency (LCA) to access them. These are examples of having an active discharge plan in place and reflect that the nursing home's ability to develop, coordinate, and implement a person–centered discharge plan and process without the need for a LCA. An active discharge plan does not mean that a resident is ready for immediate discharge since some resources such as long-term waiting lists for housing could take several months. If such an active discharge plan is in place, the assessor is instructed to skip to item Q0600-Referral. At item Q0600, a determination should be made if a referral to the LCA is needed to assist in the discharge planning process. For all residents, the SNF/NF should be consistently implementing a person- centered assessment and care planning process and the LCA should be contacted if needed and beneficial for the resident and SNF/NF to get information about available community care options and supports (Q0600 coded as "2, Yes"). Most LCAs provide information and referral services to all individuals regardless of payer source. If the resident's discharge plan has been completely developed by the nursing home staff, the care planning team determines that the designated local contact agency does not need to be contacted (Q0600 coded as "0, No").

SMAs, LCAs, and NF/SNFs need to work together to address any issues of referral concerns or confusion, the State Level point of contact (POC) can be contacted to assist all state stakeholders moving forward. The updated POC list can be found under the downloads 'MDS 3.0 Section Q implementation Solutions (Conference & Email Follow-up) [PDF, 97KB]' at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage

2. **Is our understanding correct that if nursing facilities (NF) are answering the feasibility question 0400B as 0 – [determination not made] for residents who have been diagnosed with dementia and/or Alzheimer's disease, the assessor must ask the resident question 0500B - do you want to talk to someone about returning to the community? What is CMS expectation about the State's, LCA's and Nursing Facility's obligation when a person is diagnosed with dementia, requires 24/7 care and may or may not have an informal support system? What are other state's experiences with this issue?**

Background:

Ohio has a slightly different methodology for the MDS Section Q referrals as approved in our MFP operational protocol. In Ohio, the State Medicaid Agency is responsible for passing the MDS Section Q referrals to the LCA's. Therefore, Ohio has a vested interest in how the MDS Section Q assessment is completed as well as ensuring that person-centered planning is being delivered. The state of Ohio's opinion is that regarding residents with Alzheimer's and/or dementia and no family or informal support systems, posing question Q0500B - "do you want to go home?" is inappropriate and contrary to the intent of MDS Section Q which is to provide person centered planning. Therefore, when a resident has been diagnosed with dementia and does not have family/guardian or informal support systems, Ohio proposes to instruct NF's to complete question 0400B with the assistance of their interdisciplinary team and advise them to make the determination regarding question 0400B as 2 [not feasible], thereby skipping the remaining questions in Section Q. In summary, Ohio wants to provide a clear, consistent message to our colleagues administering MDS in the NF and the LCA who is

acting on the MDS referral about how to address one of our most vulnerable populations, their families and/or guardians without undue stress.

The RAI manual indicates that the nursing home interdisciplinary team should not assume that any particular resident is unable to be discharged. The nursing home should code Q0400B as 2 after they have fully explored the resident's preferences and possible home and community based services/options available to the resident. If the nursing home interdisciplinary team determines that a resident with dementia cannot understand or answer the questions realistically, requires 24/7 care and does not have an informal support system, Q0400B would be coded as 2 [Discharge to community determined to be not feasible] and the assessor would skip to the next active section (V or X).

3. **When the question is asked, for Q0100 a, b, and c (Participation in Assessment), what if the resident cannot answer this question (the resident does not talk) the family or significant other and guardian are not available (cannot be reached) to answer questions for this section DURING THE ASSESSMENT PERIOD. How do you code this section? Maybe the contact cannot be reached until AFTER the assessment period and the MDS must be completed. Do you code for Q0300 B #9(unknown) and the Q0300B,(none of the above) How do you code then Q0400, Q0500 and Q0600**

   As with completion of any section of the MDS 3.0, the information is captured based on the resident's current status. So if the resident cannot participate, the family or significant other cannot participate, or a guardian or legally authorized representative cannot participate during the assessment period, then all three items in Q0100 are answered 0 - "No." In this situation Q0300 would be coded as you have stated only if this is the first assessment since the most recent entry. Otherwise, if it is not the first assessment since the most recent entry, this item would not be available for completion as it is only completed if A0310E=1 – "Yes." As for the rest of Section Q, you would answer according to what is appropriate. There are some residents who come to the facility with discharge plans already identified and therefore an active discharge plan might already be in place, and the assessor would answer Q0400A = 1 - "Yes," and skip to Q0600. Q0400B is answered only if Q0400A = 0 – "No," which indicates that there is no discharge plan is in place for the resident to return to the community. Questions would be answered based on the resident's interview and their individual situation.

REFERRALS TO LOCAL CONTACT AGENCIES[2]

4. **Are nursing facilities required to go through the LCAs in order to have options counseling done and/or do they make an MFP referral? Many of our nursing facilities, once Q0600 is question is answered "yes" are making those referrals themselves rather than going through the Area Office on Aging Hospital Pre-Admission Screening (PAS)/Options Counseling Coordinator?**

   Nursing facilities should follow the process that has been decided upon by their State and all stakeholders and are required by federal rule/guidelines to refer a resident to the state-designated local contact agency when appropriate under MDS 3.0 Section Q. Specifically who those agencies are is to be determined by each state. In some states they are the Aging

[2] Additional LCAs Q & A responses can be found on pages 5-9 and 22-28 in 'MDS3_0_Section_Q_Implementation_problems and solutions' under download at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp

and Disability Resource Center or the local Money Follows the Person agency or a single entry point agency or an Independent Living Center. In some states, they are multiple agencies. The goal is to provide a timely and supportive response to the resident and their family. It appears that this question needs further discussion and development of local referral protocols with your state Point of Contact and the other affected agencies.

5. What triggers a referral to the LCA? Is it from data runs from the flat file after duplicates are removed, phone, email or the state's online web referrals?

The NF is responsible for making referrals to the LCAs under the process that the State has set up. The LCA is responsible for contacting referred residents and assisting with transition services planning. They should work closely together. The LCA is the entity that does the community support planning, (e.g. housing, home modification, setting up a household, transportation, community inclusion planning, etc) A referral to the LCA may come from the nursing facility by phone, by e-mails or by a state's on-line web process. In most cases, further screening and consultation with the resident, their family and the interdisciplinary team by the nursing home social worker or staff member would likely be an important step in the referral determination process. States have flexibility in the design of their response to Section Q. While CMS does not provide specific state, nursing facility or LCA instruction as far as processes, CMS has communicated general guidance in previous Q & A responses:

- Discharge planning continues to the responsibility of the nursing facility. The LCA can be a new partner to collaborate with, particularly on difficult to place clients and offer expanded resources. In general, the LCA's role is to contact individuals referred to them by nursing facilities through the Section Q processes in a timely manner, provide information about choices of services and supports in the community that are appropriate to that individual's needs, and collaborate with the nursing facility to organize the transition to community living when possible. The exact mode and content of that contact with the nursing facility resident is to be determined by each State in response to their goals for providing choices of services and settings to individuals, with substantial input from all stakeholders involved. (Page 9, #12). The LCA should have a direct conversation with the resident/family and with the SNF/NF. Local Contact Agencies and nursing facility staff should work collaboratively for effective discharge and transition planning to support the individual's choice to return to the community. The LCA should talk directly with the resident (and or family or guardian) and meet with the SNF/NF care planning team to address the resident's discharge, transition, and community services and supports needs. The Section Q assessment and potential referral process should not be considered a replacement to the facility's routine discharge planning process. It is a way of enlisting assistance and collaboration from an outside resource to work with the resident and facility to organize and implement a transition plan to return the resident to the community. (Page 10, #13). Dropping off informational brochures to the resident/family and /or not keeping the SNF/NF in the communication is not effective.
- The roles and responsibilities for LCAs are defined generally by the Section Q process, but states are given great flexibility in defining their particular activities and responsibilities. In general, the LCA's role is to contact individuals referred to them by nursing facilities through the Section Q processes in a timely manner, provide information about choices of services and supports in the community that are appropriate

to that individual's needs, and collaborate with the nursing facility to organize the transition to community living if possible. The exact mode and content of that contact with the nursing facility resident is to be determined by each state in response to their goals for providing choices of services and settings to individuals, with substantial input from all stakeholders involved…. The Section Q pilot sites found that a face-to-face contact was needed to begin developing a rapport with the individual and to provide them with adequate information specific to their individual needs and circumstances. In addition, evidence from several States under the Nursing Facilities Transition Grant programs demonstrated that face-to-face contacts were the most effective approach for creating successful transitions and is recommended for Section Q as well. (Page 13-14, #22)

- The level and type of response needed by an individual is determined on a resident-by-resident basis and is to be part of the State's design for Section Q implementation. In the Section Q pilot test, some States chose to make a face-to-face visit to each individual requesting to talk to someone. In other instances a telephone contact may be used to screen candidates and determine their specific needs and to set appointments for visits. (Page 16, #28)
- The nursing home and local agency staffs should guard against raising the resident and their family members' expectations of what can occur until more information is obtained. The nursing home and local contact agency team must explore community care options/supports and conduct appropriate care planning to determine *if* transition back to the community is possible. Enriched transition resources including housing, in-home caretaker services and meals, home modifications, etc. are now available and will grow over time. Resource availability and eligibility coverage varies across local communities and States and these may present barriers to allowing some resident's return to their community. Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident's medical needs, finances and available community transition resources. (Page 17-18, #31)
- Discharge planning follow-up is already a regulatory requirement (CFR 483.20 (i) (3)) and important for person-centered care. The optional Return to Community Referral Care Area Trigger checklist states that, "If the local contact agency does not contact the individual resident by telephone or in person within 10 business days, make a follow-up call to the designated local contact agency as necessary." (Page 24, #51)

IMPLEMENTATION RESOURCES[3]

6. Can you verify whether there is a glitch in skilled nursing facility care area assessment (CAA) roster system for CAA 20 – Return to Community that does not allow Section Q trigger information for the Ombudsman?

The ASAP system did not edit for CAA 20 with the October, 2010 release. Beginning with the October, 2011 release (9/18/2011), CAA 20 will be edited on all records submitted after the release (9/18/2011). Any record that fails the edit for CAA 20 will be rejected with a fatal error.

[3] Additional Implementation Resources Q & A responses can be found on pages 11-12 under download 'MDS3_0_Section_Q_Implementation_problems and solutions' at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp

The CAA 20 specification was available for facility vendor software developers to implement with any of their releases. If the facility's electronic software did not implement the CAA 20 trigger, then, during MDS 3.0 national training, CMS has instructed providers that the SNF/NF needs to be manually triggered and the # 20 Return to Community CAA needs to be performed if triggered.

GUARDIAN/LEGAL REPRESENTATIVE [4]

7. Does the RAI manual indicate that only the guardian for the resident and not the resident that the guardian is responsible for should be asked Q0500 questions?

Background:
Previous CMS guidance seems to state that regardless of whether one has a guardian or not, the section Q0500 questions need to be asked unless state law prohibits it. In Nebraska, we do not have state law that would prohibit asking the Q0500 questions. However, we do need clarification on one point. Nebraska's State Survey Section Administrator notes a conflict with the MDS 3.0 manual because State Survey has been instructing surveyors to not ask residents with guardians the section Q questions. There seems to be a conflict since the RAI manual appears to be saying that if a resident has a guardian, Section Q questions should not be asked of the resident, but be asked of the guardian instead.

If a resident can respond and understand the questions, the resident should be asked the questions. In addition, if a resident has a guardian the guardian should also be asked the questions and information should be provided to the guardian on community care options, services, and supports. Many guardians do not know what care options are available in the community. However, in a few States, a state law may prohibit asking this question of specific residents. The legal status of the resident-guardian relationship may need to be verified in your state.

EXPECTATIONS[5]

8. What is expected for residents on these locked behavioral units regarding discharge planning, and community referral? Would the expectation be to code in Q0400B as 2 [Discharge to community determined to be not feasible] which then skips past referral to next section? Or, is the expectation to always refer when the resident requests no matter how minimal the feasibility is?

[4] Additional Guardianship Q & A responses can be found on pages 16-17 under download 'MDS3_0_Section_Q_Implementation_problems and solutions' at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp
[5] Additional Expectation Q & A responses can be found on pages 17-20 under download 'MDS3_0_Section_Q_Implementation_problems and solutions' at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp

Background:
For a resident on a locked unit, I would think that feasibility to be discharged in near future to be minimal. One would reassess on the next assessment regarding feasibility (perhaps no longer needs to be on the locked unit) and then could refer to LCA if the resident wishes to speak to someone about return to the community. As an RAI Coordinator, I think the concern on both the provider and the surveyor side is that if the resident requires a locked unit to control mental health behavioral issues then this would not be the appropriate time to refer to a LCA.

As with dementia or Alzheimer's residents, there is not an assumption these residents cannot be discharged. If after exploring the resident's preferences and possible home and community based services/options available to the resident, the assessor determines the resident's psychiatric status, behavior and safety would not allow discharge, Q0400B would be coded as 2 [Discharge to community determined to be not feasible] and the assessor would skip to the next active section (V or X). The feasibility of discharge should be revisited upon future assessments or at a significant change assessment especially if the resident no longer requires a locked unit.

9. Will local contact agencies (LCAs) and Money Follows the Person (MFP) organizations work with Veterans Administration (VA) Community Living Centers (formerly called nursing homes) and State Veterans Homes (SVHs)?

Yes, CMS expects LCAs, SMAs, and MFPs etc. to work with Veterans Administration Community Living Centers (CLCs) (formerly called nursing homes) to provide information on available community supports and services and, if needed, work with CLCs on transition planning for Veterans who are Medicaid eligible. Community Living Centers, which are VA owned and operated, and Nursing Facilities that have contracts with the VA may or may not require the LCA to be involved depending on the individual's level of Medicaid eligibility because planning for transition services and/or community supports are usually handled by VA social workers and interdisciplinary staff.

For SVHs, it is appropriate for the SMA and LCA to be involved since Veterans (if they choose) should also be provided information about available community care supports and options. If the Veteran is Medicaid eligible, transition planning services can also be provided to assist them to return to the community. As with other nursing home residents, the veteran, their families and SVH staff may not know the home and community based services (HCBS) that are available and may have concerns about the level of care supports available and ensuring the Veteran's health and safety in the community. The VA, States, and CMS expect that Veterans' choice and preferences are assessed, and the opportunity to get information about available HCBS services and transition back to the community is available.

'State Veterans Home List' will be posted under downloads on CMS's website at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp.

10. When will the State Veterans Homes begin to use MDS 3.0?

SVHs are considered nursing homes and 55% of the 137 SVHs are certified by CMS to receive payment under the Medicare or Medicaid programs. These facilities implemented MDS 3.0 on October 1, 2010. The community nursing facilities contracting with the Veterans Administration also implemented MDS 3.0 on October 1, 2010. The remaining non-CMS certified homes will be required to use MDS 3.0 when a Federal regulation is published, which may take several months. Some of these non-CMS certified SVHs have voluntarily switched to MDS 3.0 already. Other SVHs tried unsuccessfully to switch but returned to MDS 2.0 because of software problems.

11. How can the VA Aid and Dependent Care benefit be accessed in developing transition community care plans?

Background

I'm really interested in knowing to what extent this benefit can be accessed as a part of the home and community-based care package for eligible veterans. I understand it is a little known resource. There are not enough Medicaid services available in Florida to meet the needs of home and community-based options for those transitioning from a nursing home. In addition, there are folks who are not Medicaid eligible and are also not able to purchase HCB services on their own.

Since the VA benefit can help veterans and their families defray costs, it is important that this benefit be accessed as a part of the home and community-based care package for eligible veterans. Veteran's benefits have sometimes complex service eligibility requirements, and some veterans do not qualify for Medicaid. In addition, if a veteran is eligible for Medicaid, the Medicaid eligibility and services vary across States. If a LCA referral is received from the SVH, it is expected that the LCA and the SVH social worker work together to identify what available VA and Medicaid coverage and services are available to that individual to assist with transition back to the community with HCBS services. VA benefits information is available at http://www.vba.va.gov/VBA/.